MHAMD_FAV_SB0624
Uploaded by: Altema, Irnande
Position: FAV

mhamd
MENTAL HEALTH ASSOCIATION OF MARYLAND

Heaver Plaza
1301 York Road, #505
Lutherville, MD 21093
phone 443.901.1550
fax 443.901.0038
www.mhamd.org

Senate Bill 624 Health – Mobile Response and Stabilization System for Children and Families in Maryland - Study

Finance Committee

February 18, 2020

Position: SUPPORT

The Mental Health Association of Maryland is a nonprofit education and advocacy organization that brings together consumers, families, clinicians, advocates and concerned citizens for unified action in all aspects of mental health, mental illness and substance use. We appreciate this opportunity to present testimony in support of Senate Bill 624.

SB 624 requires the Maryland Department of Health and the Governor's Commission to Study Mental and Behavioral Health in Maryland to jointly develop a comprehensive mobile response and stabilization system for children and families.

Mobile Response and Stabilization Services (MRSS) is an upstream intervention that is primarily used to divert youth from higher intensity of services such as inpatient and residential care. MRSS is designed to assist a child in crisis by connecting families to behavioral health providers in the community that are trained to respond to acute needs. MRSS has helped with preventing repeated hospitalization, stabilizing behavioral health needs, and improving functioning in life experiences.

Maryland is experiencing a growing number of children and adolescents experiencing lengthy stays in local emergency rooms while they await transfer to a more appropriate facility for their behavioral health concerns. The Maryland Health Care Commission reports that 29 acute care general hospitals in the state provide inpatient psychiatric services for adults, only five of them for children aged 13 to 17, and only two provide care for children aged 0 to 12. These services are more accessible to children and youth outside of rural areas, but there are even more limited resources for children and adolescents in rural neighborhoods.

Currently, MRSS for adolescents exists only in Montgomery, Calvert, Baltimore, and Carroll counties. The only jurisdiction with acute children's psychiatric units is Baltimore City. The Maryland Hospital Association released data demonstrating that some children have been hospitalized "more than 100 days past medically necessary while they waited for a transfer."[1] Emergency room visits are expensive for a single night, with costs rising dramatically for every additional night. Rural areas with a shortage of resources primarily rely on the local hospital to

[1] The Washington Post. "MD youths needing psychiatric care find long waits, drives." December 11, 2019. (https://www.washingtonpost.com/local/md-youths-needing-psychiatric-care-find-long-waits-drives/2019/12/11/516058a2-1c6e-11ea-977a-15a6710ed6da_story.html)

meet their behavioral needs. There lacks a program for these communities that must travel long distances for care, even during a crisis.

SB 624 will require development of the infrastructure necessary to address the critical behavioral health needs for Maryland's children and youth in crisis. For this reason, **MHAMD supports this bill and urges a favorable report.**

For more information, please contact Irnande Altema at (410) 967-3164

Biscoe_FAV_SB624
Uploaded by: Biscoe, Julie
Position: FAV

Julie Biscoe
1550 Alconeury Road, Apt. K
Essex, MD 21221
443-509-6222
Juls826@yahoo.com

SB624
Health – Mobile Response and Stabilization System for Children and Families in Maryland – Study

Favorable

My story is not very different than what you would hear from hundreds of families in Maryland. I have a son, now 12, who has been diagnosed with Attention Deficit Hyperactivity Disorder and Disruptive Mood Dysregulation Disorder. He repeatedly goes into crisis – throwing things around and threatening to hurt himself or other members of the family. I have tried calling the mobile crisis team in Baltimore County a number of times and have never gotten help – they are either too far away, or at another crisis. One time they just told me to take my child to the emergency department. So when my son goes into crisis I call the police. Some are very helpful and know how to talk to my child. Others have no training and end up putting him in handcuffs and taking him to the emergency department.

We have had multiple stays in emergency departments. We have waited up to four days in EDs (one to three days is not uncommon), because of backed up inpatient units. When my son is in the ED, I am required to stay with him at all times. When I was a single mom I had no idea how I would have my other child taken care of. This is a tremendous hardship on the entire family. Sometimes my son would stabilize as we lingered in an ED, waiting for an inpatient bed, so I would just take him home.

My son now is involved with juvenile services, which might have been avoided with the right crisis intervention. My son was in crisis and wanted to elope from school. A school staff person tried to reason with him and my son slapped him in the face. The staff pressed charges, so my son now has an assault charge on his record.

My son is on Maryland Medicaid, so all of these ED visits and inpatient stays come at a significant cost to the state. How much better it would be for everyone if a mobile team, trained in children's mental health services, could come out to the house and help to stabilize him. This would be beneficial to the school too, because sometimes he goes into crisis there.

Thank you for reading my story.

Please give SB 624 a favorable report.

sb 624_MAYSB_FAV
Uploaded by: Ciekot, Ann
Position: FAV

Maryland Association of Youth Service Bureaus

"Being here for Maryland's Children, Youth, and Families"

Testimony submitted to Senate Finance Committee

February 18, 2020

Senate Bill 624 – Health - Mobile Response and Stabilization System for Children and Families in Maryland - Study

Support

The Maryland Association of Youth Service Bureaus, which represents a statewide network of Bureaus throughout the State of Maryland, supports Senate Bill 624, Health - Mobile Response and Stabilization System for Children and Families in Maryland - Study. Youth Service Bureaus provide prevention, intervention and treatment services to at-risk youth and work with many youth in crisis. These youth and their families often need immediate mental health services to assess and stabilize the young person in crisis. MAYSB believe that this bill would benefit youth, families and their communities by examining the issue and working to develop and implement a comprehensive mobile response and stabilization system for children and families.

This bill requires the Maryland Department of Health and the Governor's Commission to Study Mental and Behavioral Health in Maryland to jointly review data, look at current and possible future funding streams, and to develop a plan for a statewide mobile crisis system. Currently access to mental health services for children and youth have many gaps in the State, especially in rural areas of the State.

We respectfully ask you to Support this bill.

Respectfully Submitted:

Liz Park, PhD
MAYSB Chair
lpark@greenbeltmd.gov

NAMI_FAV_SB 624
Uploaded by: Cypers, Moira
Position: FAV

February 18, 2020

Senate Bill 624 - Health - Mobile Response and Stabilization System for Children and Families in Maryland – Study - SUPPORT

Chair Kelly, Vice Chair Feldman, and members of the Senate Finance Committee,

The National Alliance on Mental Illness, Maryland and our 11 local affiliates across the state represent a statewide network of more than 45,000 families, individuals, community-based organizations and service providers. NAMI Maryland is dedicated to providing education, support and advocacy for persons with mental illnesses, their families and the wider community.

NAMI Maryland strongly supports SB 624, the first step in addressing an enormous gap in behavioral health services for the most vulnerable among us: children. This bill would require the Maryland Department of Health and the Governor's Commission to Study Mental Health and Behavioral Health in Maryland to jointly develop a comprehensive mobile response and stabilization system for children and families.

Many of NAMI Maryland's members are family members, meaning they find NAMI when they're looking for education, resources, and ways to support their loved ones on their treatment path.

We have many first-hand accounts about how the lack of a comprehensive continuum of care for kids in Maryland means a struggle to find help in times of crisis. Emergency department wait times continue to grow for our children and adolescents while they wait for transfer to a more appropriate care setting.

Across the state, there are 29 acute care general hospitals that provide inpatient psychiatric services for adults 18 and older. Only five of those hospitals provide acute care for adolescents between 13 and 17, and only two provide care for children from 0 to 12 years of age.

In 2018, there were 12,304 juvenile visits to emergency departments. Close to 1,200 of them lasted anywhere from over 24 hours to 20 or more days in the emergency department, waiting for a bed elsewhere.

These alarming statistics help highlight the need for better community crisis services and interventions. A system like Mobile Response and Stabilization Services (MRSS) - an upstream intervention that is primarily used to divert youth from the higher intensity of services such as inpatient and residential care.

We need a model that's child and family focused, works with crisis as defined by the family, avoids law enforcement, provides 'round the clock access to face-to-face provider services, and is no-cost. MRSS may sound like a lot, but it's the minimum of what our kids deserve.

And we know that the earlier the intervention, the greater the potential for successful outcomes and local and statewide cost savings on both the public safety and health care front.

SB 624 would ensure Maryland is a leader on caring for our children facing tough behavioral health needs. The lack of services is so great and the need is so high. A plan like the one proposed in SB 624 would build a strong foundation to help support our kids in crisis.

For these reasons, NAMI Maryland asks for a favorable report on SB 624.

Contact:
Moira Cyphers
Compass Government Relations
MCyphers@compass-gr.com
(301) 318-4220

MCF_FAV_SB624
Uploaded by: Geddes, Ann
Position: FAV

SB 624 – Health – Mobile Response and Stabilization System for Children and Families in Maryland - Study

Committee: Finance
Date: February 18, 2020
POSITION: Favorable

The Maryland Coalition of Families: Maryland Coalition of Families (MCF) helps families who care for someone with behavioral health needs. Using personal experience as parents, caregivers and other loved ones, our staff provide one-to-one peer support and navigation services to parents and caregivers of young people with mental health issues and to any loved one who cares for someone with a substance use or gambling issue.

MCF enthusiastically supports SB 624.

Psychiatric emergency department usage by children and adolescents in Maryland has soared. In 2010 there were approximately 10,000 visits to emergency departments for psychiatric issues; in 2018 that number was 12,304. Even more troubling, in 2010 only 232 youth with psychiatric needs stayed in the emergency department longer than 24 hours; in 2018 that number was 1,163. The reasons for this are many: more youth with complex mental health needs; a clogged system where there are few open Residential, Treatment Center beds, so fewer available inpatient beds, so longer waits in emergency departments; and the absence of intensive community based services that could divert kids from emergency departments and inpatient units. Everyone agrees that this is a bad situation. Hospitals don't like it, families don't like it, and most important, it's bad for kids - emergency departments are a traumatic environment for children in a mental health crisis.

When MCF held focus groups with families of children who had used crisis services, 85% had used emergency departments. Almost all reported negative experiences – judgmental staff lacking in empathy, surrounding chaos, lengthy waits, and not being able to leave their child's room for more than a brief period of time, sometimes for days on end. Nonetheless, they felt that the emergency department was their only option. They either brought their child to the emergency department themselves, or they called 911 and the police brought their child to the emergency department – usually in handcuffs.

There is a way to address this untenable situation, and it is a mobile response and stabilization system (MRSS) for children. Other states that have a MRSS have been shown to experience a decrease in emergency department usage, a decrease in

inpatient admissions, a decrease in the number of placements for children in foster care, and a decrease in referrals to the Department of Juvenile Services. Along with the alleviation of children suffering, all of these outcomes have produced savings to the states.

There are a number of groups in Maryland that have called for the development of a robust crisis system for children and adolescents as a way to address some of the many current problems: the Children, Young Adults and Families Committee of the Behavioral Health Advisory Council; the Children's Behavioral Health Coalition, the Children and Families subcommittee of the Lt. Governor's Commission on Mental and Behavioral Health; and the Post-Acute Care Workgroup. There is consensus that a MRSS is a missing piece that would dramatically improve Maryland's system of care for children.

Along with a 72 hour mobile response, key components of a MRSS are eight weeks of stabilization services and linkages to high-fidelity wraparound services. The Administration must look at how to re-implement high-fidelity wraparound in Maryland, which SB 624 calls for. High-fidelity wraparound is an evidence-based practice that has been shown to dramatically improve outcomes for children with behavioral health needs. It is an important intensive community-based service that is now missing from Maryland's system of care, to the detriment of the entire system.

We urge a favorable report on SB 624.

Contact: Ann Geddes
Director of Public Policy
The Maryland Coalition of Families
10632 Little Patuxent Parkway, Suite 234
Columbia, Maryland 21044
Phone: 443-741-8668
ageddes@mdcoalition.org

MARFY_Pam Kasemeyer_FAV_SB0624
Uploaded by: Kasemeyer, Pam
Position: FAV

Maryland Association of
Resources for Families & Youth

TO: The Honorable Delores G. Kelley, Chair
Members, Senate Finance Committee
The Honorable Joanne C. Benson

FROM: Pamela Metz Kasemeyer
Danna L. Kauffman
Richard A. Tabuteau

DATE: February 18, 2020

RE: **SUPPORT** – Senate Bill 624 – *Health – Mobile Response and Stabilization System for Children and Families in Maryland – Study*

The Maryland Association of Resources for Families and Youth (MARFY) is a statewide network of private agencies serving at-risk children and youth and advocates for a system of care in Maryland that meets the needs of children and families. MARFY is a program of Maryland Nonprofits and **supports** the passage of Senate Bill 624.

Senate Bill 624 requires the Maryland Department of Health (MDH) and the Governor's Commission to Study Mental and Behavioral Health in Maryland to study and make recommendations on the development and implementation of a comprehensive mobile response and stabilization system (MRSS) for children and families. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), MRSS is designed to intercede in urgent behavioral situations, before such situations become unmanageable emergencies. SAMHSA identifies MRSS as a viable alternative to acute care and residential treatment because MRSS programs demonstrate cost-savings while improving outcomes. Similarly, the 2019 report of the Governor's Commission found that crisis services are an integral part of the health care system and critical to patients and families in need.

All youth in Maryland should have access to appropriate services, regardless of their level of need. The system of care is designed to have a graduated level of care, depending on the needs of the child, starting with community-based prevention services. Providers know that if there is access to clinically appropriate services on the front end for youth in care then we can significantly reduce the number of youth requiring hospitalization and stop using hospitals as placement, which now occurs as a result of the current lack of resources. Maryland needs substantial resource development (i.e. creation of new programs) and funding to match the growing needs of the youth in child welfare. One part of the system that is present in other states and is woefully lacking in Maryland is the availability of 24/7 mobile crisis services that result in reducing the need for higher levels of services. Passage of Senate 624 will provide a framework for the development of a critical component of an effective and comprehensive system of care for Maryland's children and families. A favorable report is requested.

For more information call:
Pamela Metz Kasemeyer
Danna L. Kauffman
Richard A. Tabuteau
(410) 244-7000

MRSS_FAV_SB624
Uploaded by: Manley, Elizabeth
Position: FAV

SB 624 – MOBILE RESPONSE AND STABILIZATION SYSTEM FOR CHILDREN & FAMILIES IN MARYLAND - SUPPORT

My name is Elizabeth Manley and I am a subject matter expert on children's behavioral health services. I am a Clinical Instructor for Health and Behavioral Health Policy at the Institute for Innovation and Implementation, at the University of Maryland School of Social Work. I am here today to talk to you about the importance of developing and implementing a comprehensive mobile response and stabilization system for children and families. This is based both on my experience in leading this work for years in New Jersey as well as my work with other states and communities. In my role with the TA Network, the federally funded National Training and Technical Assistance Center for Children's Behavioral Health, I assist states in addressing the critical needs presented by the overuse of emergency departments, inpatient psychiatric units, and residential services in response to crises. States and communities that have invested in a children's specific Mobile Response and Stabilization within the continuum of a care have benefitted from decreases in the over-reliance of the highest intensities of service including inpatient care.

Prior to joining the University of Maryland School of Social Work in 2017, I served as Assistant Commissioner for New Jersey's Children's System of Care, the division within the state that has direct oversight of the public mental health system for children. I was in that role for 5 years and was engaged in multiple aspects in the implementation of the system of care in New Jersey. In 2006, New Jersey mobile response and stabilization system statewide implementation was completed. Since then, 94 percent of children have been able to stay in the same living situation they were in at the time the crisis service was received, reducing the number of youth entering emergency department. Mobile response and stabilization has contributed to the stability of children in foster care, reducing the number of behavioral driven moves in foster care.[1] In New Jersey, Mobile Response and Stabilization is available at the request of parents and caregivers and is responsive to law enforcement, education, juvenile justice and child welfare systems.

For years now, we have known that mobile response and stabilization services are a national best practice to address crises, maintain children in a family-setting in the community, and reduce utilization of emergency departments, inpatient hospitals, and residential treatment. In 2013, the Centers for

[1] https://www.nj.gov/dcf/about/divisions/dcsc/CSOC_15.Year.Conference.Presentation.pdf

Medicare and Medicaid Service (CMS)[2] and the Substance Abuse and Mental Health Services Administration (SAMHSA) recognized mobile response and stabilization services as an essential service for consideration within a children's behavioral health continuum. In September 2018 the National Association of State Mental Health Program Directors recognized Mobile Response and Stabilization is a core element within a children's crisis continuum of care.[3]

New Jersey built a system where Mobile Response was available to any family, anywhere at any time. 24 hours a day, 7 days a week, 365 days a year, Mobile Response provides immediate support to any family in crisis because of a child's escalating emotional or behavioral health needs. It can be the families' first time calling or a repeat request for help. The response operates through a trauma informed lens to quickly understand what the child has experienced and then helps the child stabilize and feel better. New Jersey's guiding and fundamental philosophy is that "When a child feels better, they do better". Mobile response in New Jersey has one-hour response time and with a single point of entry toll free line and provides this 4-pronged approach:

1. Onsite intervention to deescalate, shift dynamics and provide education.
2. Assessment, planning, skill building, psycho-education and resource linkage to stabilize presenting needs.
3. Assistance to the child and family to return to baseline or routine functioning and prevention of further escalation.
4. Provision of prevention strategies and resources to cope with presenting issues and create a plan to avoid future crises.

Maryland already has been working on a shared vision. For the last 4 years, my colleague Jennifer Lowther, has been gathering and leading a group of invested professionals through Maryland's Mobile Response Stabilization Services Collaborative that is comprised of representatives from all of Maryland's child servicing sister agencies to include BHA, GOC, DHS, DJS, DDA, MSDE, Medicaid, various core service agencies, local mobile response providers, advocates, University of Maryland researchers. All members

[2] https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/CIB-05-07-2013.pdf

[3] https://nasmhpd.org/sites/default/files/TACPaper8_ChildrensCrisisContinuumofCare_508C.pdf

would agree that diverting youth from higher intensity services such as inpatient and residential care; facilitating the coordination of stabilizing youth in their community; providing acute care to children and youth in rural areas with limited resources and community programs; reducing length of stay in residential programs and ultimately increasing cost-savings as a result of increased hospital diversions are all important goals.

There are several states that have been have invested in building comprehensive systems for children. Two of these states include Nevada and Oklahoma who have both demonstrated a return on investment that included reduction in inpatient stay and visits to emergency departments and increase satisfaction of families whose needs were met when their immediate crisis was stabilized, which allowed children to stay in school and with their families. With the support of leadership to take action to better serve the children and families struggling today to access the right service at the right time for the right duration.

Thank you for time and interest in children's mobile response and stabilization.

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Millward_FAV_SB624
Uploaded by: Millward, Beth
Position: FAV

SB624
Health – Mobile Response and Stabilization System for Children and Families in Maryland – Study

Favorable

I urge you to pass SB 624.

I have an 11 year old son with PTSD, ADHD, Anxiety and Depression. His father completed suicide two years ago, and this has severely impacted my son's mental health.

Because of his mental health issues, my son has not been to school at all this year. We have been trying everything to get him the treatment that he needs, but he refuses to go and completely shuts down.

I have tried calling the mobile crisis team in Baltimore County multiple times, but they have not responded. I have been told that they can't come out, that no one is available.

So we have been to the emergency department seven times in the last 1½ years because of his going into crisis. Sometimes I have taken him there, most often I have called 911 and the police have taken him to the ED in handcuffs.

We have had horrible experiences in the ED. Lengthy waits while the staff tried to find an inpatient bed for him – usually there are none and we just have him discharged home. Plus I have to stay with him when he is in the ED, but I am a single mom with 2 other children. What am I supposed to do?

Mobile crisis teams designed for kids that come into the home and deal with the crisis there would be incredibly helpful to me and my children, as would in-home services after the acute crisis passes.

Please support SB 624.

Beth Millward
1204 June Road
Halethorpe, MD 21227
410-980-4263
Elizabeth.millward@ascension.org

DisabilityRightsMD_FAV_SB624
Uploaded by: Parsley, Luciene
Position: FAV

Empowerment. Integration. Equality.

1500 Union Ave., Suite 2000, Baltimore, MD 21211
Phone: 410-727-6352 | Fax: 410-727-6389
www.DisabilityRightsMD.org

Disability Rights Maryland
Testimony before the Senate Finance Committee
February 18, 2020

Senate Bill 624 – Health Response and Stabilization System for Children and Families in Maryland – Study - Requiring the Maryland Department of Health and the Governor's Commission to Study Mental and Behavioral Health to jointly develop a comprehensive mobile response and stabilization program.

POSITION: SUPPORT

Disability Rights Maryland (DRM) is the federally-mandated Protection and Advocacy agency for the State of Maryland, charged with defending and advancing the rights of persons with disabilities. DRM advocates for systemic reforms and policies that improve services and supports for persons with psychiatric disabilities, and ensures that their rights are protected. DRM is here today to support Senate Bill 624, which would require the Department of Health and the Governor's Commission to jointly develop a comprehensive mobile response and stabilization program for children and youth. Maryland's mental health system for children and youth is in crisis.

DRM maintains a presence in Maryland's public and private residential treatment centers and investigates complaints of abuse, neglect and rights violations on behalf of children with emotional and behavioral disabilities and their families. In DRM's experience, families are being forced to relinquish custody, as they did twenty years ago, to obtain appropriate mental health care for their children. Because crisis and low-level mental health treatment is largely unavailable, situations often escalates to crisis levels before families can obtain services. At that point, the child is often hospitalized, sometime for extended periods of time, children are sent to out-of-home placements, if they can get them, or children go into the juvenile justice system. We are especially concerned about the incidence of this happening to children who are dually diagnosed with developmental disabilities, such as autism or intellectual disabilities, and youth with substance abuse disorders. We receive calls on a weekly basis from families seeking help getting their children admitted to residential treatment centers or out-of-state residential placements. Parents and guardians have received the message that crisis services are largely unavailable and that a Voluntary Placement Agreement is needed to obtain Residential Treatment Center services. Unfortunately, when these parents go to their local Department of Human Services office to apply for a VPA, they are most often turned away or discouraged from applying. Parents then have nowhere to turn, so when their child is finally hospitalized with a psychiatric admission or emergency petition, sometimes parents will refuse to take the child home, as it is unsafe. This cannot be allowed to continue. Mental health services for children need to be significantly and substantially increased. Preventive services, including wraparound mental health services like the 1915i Waiver, need to be put in place. Under the Americans with Disabilities Act, children and youth with disabilities have the right to receive services in the most intengrated

setting appropriate to their needs. For most children and youth, this will be in the family home and in their communities. Failing to provide services until the child is in crisis is costly and may violate the ADA as well as other federal laws, such as the Early Periodic Screening, Diagnosis and Treatment (EPSDT), which covers Medicaid-eligible children and youth to age 21. Maryland has a 1915i waiver, but it is underutilized and ineffective. It is our understanding that Maryland began negotiating with CMS to improve the waiver but there has not been substantial progress. Creating a plan for a comprehensive mobile response and stabilization program would be a good start to give Maryland's children and youth the mental health treatment they deserve.

For these reasons, DRM recommends that Senate Bill 624 be given a favorable report.

Senator Benson_FAV_SB624
Uploaded by: Senator Benson, Senator Benson
Position: FAV

JOANNE C. BENSON
Legislative District 24
Prince George's County

Finance Committee
Chair, Rules Committee

Joint Committees
Children, Youth, and Families
Ending Homelessness
Fair Practices and State Personnel Oversight
Management of Public Funds

Chair, Prince George's County
Senate Delegation

THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

James Senate Office Building
11 Bladen Street, Room 214
Annapolis, Maryland 21401
301-858-3148 · 410-841-3148
800-492-7122 *Ext.* 3148
Fax 301-858-3149 · 410-841-3149
Joanne.Benson@senate.state.md.us

Testimony of Senator Joanne C. Benson
SB 624- Health- Mobile Response and Stabilization System for Children and Families in Maryland-Study

Good afternoon Madame Chair and esteemed Members of the Finance Committee. SB 624: Health- Mobile Response and Stabilization System for Children and Families in Maryland-Study requires the Maryland Department of Health and the Governor's Commission to Study Mental and Behavioral Health to jointly develop a comprehensive mobile response and stabilization system for children and families.

Existing behavioral health mobile response systems do not offer a comprehensive continuum of care for children and youth. This has led many parents to turn to hospital emergency departments when the child could be more appropriately served by a mobile response team in the community. Mobile Response and Stabilization Services (MRSS) is an upstream intervention that is primarily used to divert youth from the higher intensity of services such as inpatient and residential care. The MRSS Model is: child and family focused, crisis is defined by the family, voluntary, no police involvement, 24/7 access, no cost to the family, face-to-face with the provider. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) identifies MRSS as a "viable alternative to acute care and residential treatment because MRSS programs demonstrate cost-savings while improving outcomes achieving higher family satisfaction."[1] However, in the great state of Maryland, we currently lack this critical program that's designed to save our children and youth.

In 2017, the U.S. Department of Health found that 17% of high school students in Maryland seriously considered attempting suicide 12 months prior.[2] While 49,000 adolescents aged 12-17 (10.8% of adolescents) per year in 2013-2014 reported using illicit drugs within the month prior to being surveyed and 21,000 adolescents aged 12-17 (4.6% of all adolescents) per year in 2013-2014 reported nonmedical use of pain relievers within the year prior to being surveyed.[3] One child lost to suicide, substance abuse, or any behavioral health illness is one too many. Thus, it is imperative that we take advantage of this wonderful opportunity to develop a comprehensive mobile response and stabilization system that can assist in crisis prevention for children and youth in Maryland.

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[1] Technical Assistance Collaborative. (2005). A Community-Based Comprehensive Psychiatric Response Service: An Informational and instructional monograph. Retrieved from http://tacinc.org/media/13106/Crisis%20Manual.pdf.
[2] https://www.hhs.gov/ash/oah/facts-and-stats/national-and-state-data-sheets/adolescent-mental-health-fact-sheets/maryland/index.html.
[3] https://www.samhsa.gov/data/sites/default/files/2015_Maryland_BHBarometer.pdf

Moreover, crisis services are more accessible to children and youth outside of rural areas, but there are even more limited resources for children and adolescents in rural neighborhoods. Rural areas with a shortage of resources primarily rely on the local hospital to meet their behavioral needs. There lacks a program for these communities that must travel long distances for care, even during a crisis.

MRSS programs are critical as they are one of the only programs that seek to assist in the de-escalation of crises, while cultivating a safety plan that allows a child or youth to be kept safe at home, in the community, or in school whenever possible. All too often we use our last resort as our first resort. MRSS has helped with preventing repeated hospitalization, stabilizing behavioral health needs, and improving functioning in life experiences.

Thus, we request a favorable report of SB 624.

MCFOF_FAV_SB 624
Uploaded by: Serkin, Celia
Position: FAV

Montgomery County Federation of Families for Children's Mental Health, Inc.
13321 New Hampshire Avenue, Suite 101
Silver Spring, MD 20904

301-879-5200 (phone) 301-879-0012 (fax)

Testimony Presented Before the Senate Finance Committee

Hearing on the SB 624: Health Response and Stabilization System for Children and Families in Maryland - Study

Tuesday, February 18, 2020

SUPPORT

My name is Celia Serkin. I am the Executive Director of the Montgomery County Federation of Families for Children's Mental Health, a family and youth support organization providing assistance to parents and other primary caregivers who are raising children or youth with behavioral health challenges. We also provide youth peer support services to youth and young adults with mental health challenges who are partially or fully disconnected, that is, they are struggling in school or with employment or are not in school and not working . I am a parent of two children, now adults, who have behavioral health challenges. As a parent, I have dealt with over 100 crisis situations with my children over the years and have had many visits to hospital emergency departments.

The Montgomery County Federation of Families for Children's Mental Health supports SB 624 requiring the Maryland Department of Health and the Governor's Commission to Study Mental Health and Behavioral Health in Maryland to jointly develop a comprehensive mobile response and stabilization system for children and families. Almost all of the existing behavioral health mobile response systems do not offer a comprehensive continuum of care for children and youth. When parents and other primary caregivers across Maryland cannot access this continuum of care, they have to turn to hospital emergency departments to get help. Whether a family lives in an urban, suburban or rural area, going to hospital emergency departments is not the answer when children and youth could be served in the community through a comprehensive system of care that includes mobile response and stabilization services. In rural areas, families must travel long distances for care, even during a crisis.[1] Due to a shortage of resources, these families primarily have to rely on the local hospital to meet the behavioral needs of their child or youth. Throughout Maryland, families often have to wait hours at the hospital to have their children assessed. When the child or youth does meet the criteria for a hospitalization, the family can wait a long time for an inpatient bed to become available. Families also have had the

experience that by the time their child or youth is assessed, their affect has changed and they will not meet the criteria for a hospitalization. The family then takes the child home. Within a short period of time, the family returns to the hospital emergency department because the child or youth is again in a crisis. Even when a child or youth is hospitalized, the stay may be short, and the child or youth returns to the community without a comprehensive step-down plan. The result is a revolving door of hospital emergency department visits.

What is needed in Maryland is the Mobile Response and Stabilization Services (MRSS), an intervention that is primarily used to divert youth from the higher intensity of services, such as inpatient and residential care. MRSS has helped with preventing repeated hospitalizations, stabilizing behavioral health needs, and improving functioning in life experiences. The MRSS model is child and family focused, with the family defining what constitutes a crisis. It is voluntary and there is no police involvement. There is 24/7 access. The family has face-to-face access to a provider, and is not required to pay for the MRSS intervention. Adopting MRSS across Maryland also will provide much needed care to children and youth in rural areas where there is a shortage of resources. At the same time, there can be cost savings through increased hospital diversion.

I can speak to the value and efficacy of MRSS as in Montgomery County, we have been able to expand our Mobile Crisis Response to include stabilization services. We have a Crisis Center that provides free crisis services 24 hours a day/365 days a year. Services are provided by telephone or in person and no appointment is needed. We also have a Mobile Crisis Team (MCT) that provides emergency crisis evaluations for children, youth, and adults who are experiencing a mental health crisis. Full crisis assessments and treatment referrals are provided for all crises, both psychiatric and situational. The Crisis Center or local schools can refer families to Care and Connections for Families at Family Services, which is part of Sheppard Pratt. Using a whole family approach, Care and Connections for Families delivers in-home counseling to support families whose children are experiencing severe emotional or behavioral problems, such as angry outbursts or impulsivity; depression or suicidal thoughts; desire to hurt someone else; self-harming actions, including cutting, burning, or scratching; unexpected decline in school performance or not wanting to go to school; and/or vandalism or other illegal activity. When a family is in need, Care and Connections for Families begins crisis intervention within hours. An intensive approach is used to quickly de-escalate a crisis and help address the root cause. The stabilization services include short-term crisis intervention and in-home counseling and support services using a team

approach. The services are family-centered and encompass the entire family's emotional and practical needs, including siblings. Therapists and in-home stabilizers provide counseling in the family's home up to four times per week. A member of the team is available by phone 24 hours a day for families who need support between appointments. The crisis intervention and counseling services are available in Spanish, Portuguese, and Amharic, thereby making it easier for families to communicate in their preferred language. Care and Connections for Families works with a family's busy schedule to meet at times that work best for them. Many families achieve good results within eight weeks. In rare cases where additional support is necessary, the workers are often able to continue working with the family until they achieve stability. Care and Connections for Families helps families maintain long-term stability by checking in 30 days after their eight-week session. Families are welcome to contact their team by phone for extra support.

These crisis intervention services address the family's immediate needs and pave the way toward a long-term, stable family environment with support services. Care and Connections for Families' efforts go beyond mental health crisis intervention. Families learn communication techniques so they can meet their child's ongoing needs. They receive referrals to local support services, including family and youth peer support, food banks, counseling, and other needed services. Care and Connections for Families uses established techniques, including dialectical behavior therapy-informed treatment (DBT), to strengthen parent-child relationships. Through DBT, family members gain change management and communication skills. Parents learn how to process their feelings effectively so that the whole family can move forward. They also learn about child and adolescent development and mood management to help them understand what their child or adolescent is experiencing, and are taught communication techniques that help strengthen family bonds. Care and Connections for Families can work with schools to address challenges with instruction or other children or youth and help develop individualized education programs (IEPs) when needed.

Thank you for your interest in children's mobile response and stabilization and for your commitment to children, youth and young adults with behavioral health challenges and their families in Maryland. We support SB 624.

[1]Cumberland Times-News. "MD youths needing psychiatric care find long waits, drives." December 26, 2019. https://www.times-news.com/news/local_news/md-youths-needing-psychiatric-care-find-long-waits-drives/article_43daf79d-ac0f-5b31-a370-af9f0314d025.html

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Position: FAV

SB624
Health – Mobile Response and Stabilization System for Children and Families in Maryland – Study

Favorable

I strongly support SB 624.

I have a daughter, now 14, who has been diagnosed with Schizophrenia, Disruptive Mood Dysregulation Disorder and Reactive Attachment Disorder. Trying to access crisis services for our family has been a nightmare.

I will give an example of the last time we needed crisis services, which was just last week. My daughter was being very aggressive and starting to have a breakdown, so I called 911. The police came, handcuffed her, and took her to Emergency Department of the local hospital. This hospital is where the police always take my daughter (or other children from our area) when they are called, but the hospital doesn't do children's mental health. We waited there for 16 hours while the ED staff tried to find a bed in a children's inpatient unit. They were unsuccessful, so they had an adult psychiatrist come down from the adult unit to sign off on her that she was ok to go home. They sent a packet of resources with us – all adult resources.

We have tried calling the mobile crisis team in our area, but usually they are not available to come out so we have to call 911 anyway. Even when mobile crisis has come out, they are not trained in dealing with children in crisis so they end up calling the police, who come out, put her in handcuffs, and take her to the emergency department of our local hospital, which as I said, doesn't do kids.

We have sat as long as four days in the emergency department waiting for an inpatient bed. This in itself is traumatic for my child. Sometimes other adults are there in the emergency department who are in a mental health crisis, which can be scary. Being handcuffed is also traumatic to my child.

I would love to have a mobile response team, trained in treating children, be able to come out to help to de-escalate the situation and prevent a trip to the emergency department or inpatient unit.

Please vote in favor of SB 624 so we can try to bring a mobile response system for kids to Maryland.

Patricia Williams
227 Mackall Street
Elkton, MD 21921
pwilliams1081@comcast.net
443-537-5121

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Position: FAV

Statement of Maryland Rural Health Association
To the Finance Committee
February 18, 2020
Senate Bill 624: Health – Mobile Response and Stabilization for Children and Families in Maryland – Study
POSITION: SUPPORT

Senators Benson, Klausmeier and Hayes, Chair Kelley, Vice Chair Feldman, and members of the Finance Committee, the Maryland Rural Health Association (MRHA) is in SUPPORT of Senate Bill 624: Health – Mobile Response and Stabilization for Children and Families in Maryland – Study.

This legislation would require the Maryland Department of Health and the Governor's Commission to Study Mental and Behavioral Health in Maryland jointly to take certain actions in order to develop and implement a comprehensive mobile response and stabilization system for children and families in the State; and requiring the Department and the Commission jointly to submit their findings and recommendations to certain committees in the General Assembly on or before December 1, 2020.

MRHA's mission is to educate and advocate for the optimal health and wellness of rural communities and their residents. Membership is comprised of health departments, hospitals, community health centers, health professionals, and community members in rural Maryland. Furthermore, Maryland law states that "many rural communities in the State face a host of difficult challenges relating to persistent unemployment, poverty, changing technological and economic conditions, an aging population and an out-migration of youth, inadequate access to quality housing, health care and other services, and deteriorating or inadequate transportation, communications, sanitations, and economic development infrastructure." (West's Annotated Code of Maryland, State Finance and Procurement § 2-207.8b)

The 2018 Maryland Rural Health Plan (www.MDRuralHealthPlan.org), an extensive assessment of Maryland's rural health needs, identified behavioral and mental health problems as a prevalent concern in many rural counties. The Commission to Study Mental and Behavioral Health in Maryland 2019 Report (www.governor.maryland.gov) puts forth several recommendations that MRHA believes would strengthen behavior and mental health care provision in Maryland's rural communities. This legislation is aimed at providing a holistic and comprehensive response to mental health emergencies for families.

MHRA believes this legislation is important to support our rural communities and we thank you for your consideration.

Lara Wilson, Executive Director, larawilson@mdruralhealth.org, 410-693-6988

MDAAP_Pam Kasemeyer_FWA_SB0624
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Position: FWA

TO: The Honorable Delores G. Kelley, Chair
Members, Senate Finance Committee
The Honorable Joanne C. Benson

FROM: Pamela Metz Kasemeyer
J. Steven Wise
Danna L. Kauffman
Richard A. Tabuteau

DATE: February 18, 2020

RE: **SUPPORT WITH AMENDMENT** – Senate Bill 624 – *Health – Mobile Response and Stabilization System for Children and Families in Maryland – Study*

The Maryland Chapter of the American Academy of Pediatrics (MDAAP) is a statewide association representing more than 1,100 pediatricians and allied pediatric and adolescent healthcare practitioners in the State and is a strong and established advocate promoting the health and safety of all the children we serve. On behalf of MDAAP, we submit this letter of support for Senate Bill 624 with the noted amendment.

Senate Bill 624 requires the Maryland Department of Health (MDH) and the Governor's Commission to Study Mental and Behavioral Health (Commission) in Maryland to study and make recommendations on the development and implementation of a comprehensive mobile response and stabilization system (MRSS) for children and families. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), MRSS is designed to intercede in urgent behavioral situations, before such situations become unmanageable emergencies. Such programs are intended to avert unnecessary emergency department visits, out-of-home placements, and placement disruptions, with the intention of reducing overall system costs. SAMHSA identifies MRSS as a viable alternative to acute care and residential treatment because MRSS programs demonstrate cost-savings while improving outcomes.

The Commission's 2019 report found that crisis services are an integral part of the health care system and critical to patients and families in need. As noted by the Commission, currently Maryland lacks a mobile response and stabilization system for children and young adults; behavioral health services for children and youth are particularly limited in rural neighborhoods; and an increasing number of residential programs are closing and outpatient substance use programs for youth ages 13 to 18 are virtually nonexistent. To that end, the development of a MRSS for children and families would provide critical services and support, reduce unnecessary hospital visits and create framework for more appropriate service delivery to children and families experiencing behavioral health crises.

The MDAAP notes that MDH and the Commission are required to consult with stakeholders in developing their recommendations. Specifically, they are required to consult with the Children's Behavioral Health Coalition and the University of Maryland's Mobile Response and Stabilization Collaborative, however it does not specifically identify the Maryland Chapter of the American Academy of Pediatrics. To that end, the MDAAP would request an amendment (listed below) to the legislation specifically including the MDAAP in the stakeholders that are required to be consulted. Not only can MDAAP provide valuable insight in the patients they serve, which are the focus of this effort, but also can leverage the myriad of resources available through the American Academy of Pediatrics national office relative to policies, programs, and approaches in other areas of the country.

Amendment: On page 2, line 32, after "Coalition" insert "<u>, Maryland Chapter of the American Academy of Pediatrics</u>"

With its noted amendment, MDAAP strongly supports passage of Senate Bill 624 as Maryland's children and families are in dire need of the services that would be available if Maryland adopts a MPSS.

For more information call:
Pamela Metz Kasemeyer
J. Steven Wise
Danna L. Kauffman
Richard A. Tabuteau
410-244-7000

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Maryland
DEPARTMENT OF HEALTH
Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

February 18, 2020

The Honorable Delores G. Kelley
Chair, Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401

Re: SB 624 –Mobile Response and Stabilization System for Children and Families in Maryland – Study - Letter of Information

Dear Chair Kelley and Committee Members:

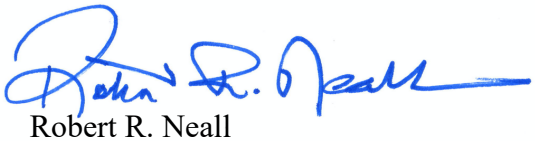
The Maryland Department of Health ("the Department") submits this letter of information regarding SB 624 - Mobile Response and Stabilization System for Children and Families in Maryland – Study.

SB 624 requires the Department to conduct a study by December 1, 2020, and plan to implement a comprehensive statewide Mobile Response and Crisis System for children and families by July 1, 2022. The System must include: 1) a 72-hour mobile response; 2) an 8-week stabilization service; and 3) intensive care coordination. The System must adhere to: 1) a system of care principles; 2) national best practices and curriculum; and 3) definitions for children, families, and a single assessment tool. Conservatively, the Department estimates establishing a System as defined in SB 624 will cost at least $27 million in total funds ($18.8M federal funds, $8.9M general funds) annually.

Expanding the crisis service network statewide has been a key focus of the Lt. Governor's Commission to Study Mental and Behavioral Health in Maryland. The Crisis Services subcommittee began meeting in early 2019 and offered its first round of recommendations in December 2019. This subcommittee will continue to meet throughout 2020. Concurrently, the Department has engaged in a substantial stakeholder-driven process to redesign the Behavioral Health system of care in Maryland. Given these two major initiatives already underway, additional work groups convened with the purpose of studying these same issues, the Department respectfully asks the Committee to consider folding this bill's intent into the ongoing efforts.

If you would have additional questions, please contact Director of Governmental Affairs, Webster Ye, at (410) 260-3190 or webster.ye@maryland.gov.

Sincerely,



Robert R. Neall
Secretary